



Send completed forms
to DOH Communicable
Disease Epidemiology
Fax: 206-418-5515

Relapsing Fever

County _____

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Other: _____
Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ Confirmed
☐ Probable
☐ No count; reason: _____

REPORT SOURCE

Initial report date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date:
____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Phone: _____

Occupation/grade _____

Employer/worksites _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived

Diagnosis date: ____/____/____

Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Fever** Highest measured temp: _____ °F
Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ **Recurring fever**
Number of attacks: _____
Days between attacks: _____

☐ ☐ ☐ ☐ **Chills**
☐ ☐ ☐ ☐ **Headache**
☐ ☐ ☐ ☐ **Muscle aches or pain (myalgia)**

☐ ☐ ☐ ☐ Malaise
☐ ☐ ☐ ☐ Fatigue
☐ ☐ ☐ ☐ Arthritis or arthralgia
☐ ☐ ☐ ☐ Other symptoms consistent with illness
Specify: _____

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Pregnant
Estimated delivery date ____/____/____
OB name, address, phone: _____

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ Complications
Specify: _____

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ____/____/____

P N I O NT

☐ ☐ ☐ ☐ ☐ **Borrelia** blood culture by special methods

☐ ☐ ☐ ☐ ☐ **Spirochetes** in peripheral blood smear by dark
field microscopy or Wright-Giemsa stain

NOTES

INFECTION TIMELINE

Enter onset date (first sx)
in heavy box. Count
backward to determine
probable exposure period

Days from
onset:

Exposure period

-15

-5

o
n
s
e
t

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or
outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____

- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**
☐ ☐ ☐ ☐ If infant, birth mother had febrile illness

- ☐ Patient could not be interviewed
☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Y N DK NA

- ☐ ☐ ☐ ☐ Insect or tick bite
☐ Deer fly ☐ Flea ☐ Mosquito ☐ Tick
☐ Louse ☐ Other: _____ ☐ Unk
Location of insect or tick exposure
☐ WA county ☐ Other state ☐ Other country
☐ Multiple exposures ☐ Unk
Date of exposure: ____/____/____
☐ ☐ ☐ ☐ Slept in cabin or outside
☐ ☐ ☐ ☐ Slept in places with evidence of rodents (e.g.
animals, nest, excreta)
☐ ☐ ☐ ☐ Wild rodent or wild rodent excreta exposure
Where rodent exposure probably occurred:

☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn
mowing, gardening, hunting, hiking, camping,
sports, yard work)

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS/TREATMENT

Y N DK NA

- ☐ ☐ ☐ ☐ Antibiotics prescribed for this illness Name: _____
Date antibiotic treatment began: ____/____/____ # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue
(including ova or semen) in the 30 days before
symptom onset? Date: ____/____/____
Agency and location: _____
Specify type of donation: _____
☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Notify blood or tissue bank
☐ Education on rodent control
☐ Other, specify: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ____/____/____

Local health jurisdiction _____

Record complete date ____/____/____